Fall 1998

OSHPD MONITOR

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

OSHPD's Safety Assessment Teams

Fall 1998

The purpose of the OSHPD Monitor is to promote communication with our clients, health care providers, health professional training programs, associations, legislative representatives, and the public.

The mission of the Office of Statewide Health Planning and Development is to plan for and support development of health care delivery systems that meet the current and future needs of the people of California.

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OSHPD's Safety Assessment Teams

On-call and ready for the next big quake

"In a disaster, the need for medical care is immediate, often with life-threatening situations for a large number of people."

California is prone to earthquakes with known and unknown faults running through many of its major cities. In the event of a significant earthquake or other natural disaster affecting the structural integrity of a health care facility, OSHPD must be ready to rapidly assess all acute care hospital, skilled nursing and intermediate care buildings to ensure they are safe for occupancy. OSHPD has formulated an emergency response plan that describes this response in detail.

The OSHPD Safety Assessment Team is responsible for the inspection and safety posting of each facility in the affected area. However, the facility's inspector or local building inspector may elect to inspect the building first, for initial damage estimates and liability reasons. This initial inspection may assist in determining the priority of the OSHPD team's assessment.

OSHPD's Plan provides for emergency response teams consisting of three technical members; one Area Compliance Officer, one Structural Engineer, and one Fire and Life Safety Officer. The team's objectives are to provide emergency structural, critical nonstructural and fire and life safety assessments. They ensure rapid and expert safety inspection of facilities in an earthquake disaster area and provide information to the Health and Welfare Agency, the Office of Emergency Services, Emergency Medical Services Authority and other agencies as necessary. Information on which facilities are open and operating and which ones are closed, and their condition, is essential in providing medical care.

What this means is that the team will determine if the health facility is still useable, or if portions or all of the building should be evacuated. The team must be alert to hazards inherent in damaged structures. Before entering a building, the response team will inspect its exterior and entire perimeter for such hazards as falling glass or building ornamentation. The response team will not enter buildings near collapse, or where there has been a hazardous materials release. If the team can enter the building, the interior is inspected for structural and nonstructural damage such as cracked walls, support columns and/or beams, fallen ceilings, broken piping and ductwork, overturned partitions and heavy furniture. If a hazardous material spill is discovered, the team would notify the proper authorities. The team's detailed assessment forms will be transmitted to OSHPD headquarters in Sacramento.

After each inspection by the Response Team, the main entrance of the building is posted with a green, yellow, or red placard. A green placard posting signifies that the OSHPD team has evaluated the building and determined that it is safe for occupancy. This posting does not imply that minor damage should be ignored or that repairs are unnecessary. A yellow placard means the Team has evaluated the building and observed damage, which precludes unrestricted

occupancy. Examples may include the loss of use of basic sanitary facilities due to broken water or sewer pipes or damage to the fire sprinkler system. Localized structural damage may also place a portion of a building in an unsafe condition while other areas remain useable. Overall damage may be of the level where contractors can enter to make repairs, although the facility is too damaged for normal occupancy. A red placard means that the building has been determined to be unsafe to occupy, for any reason. The red placard is posted when there is an immediate risk associated with entry, use or occupancy; it does not automatically mean the building has been condemned, or will require demolition. Aftershocks could create new damage or increase the initial damage to health facilities, causing the need for re-inspection of a building and a change in posting. OSHPD has the final responsibility for posting a building or changing the type of posting. During the 1994 Northridge earthquake, a powerful tremor that measured 6.7 on the Richter scale, one wing of a hospital was damaged due to broken water lines that flooded the area. Only the wing involved was unusable but the rest of the building was OK. The wing was originally tagged red but later changed to yellow after emergency repairs were made.

In a disaster, the need for medical care is immediate, often with life-threatening situations for a large number of people. This includes those already admitted to the hospital and under care as well as those injured in the disaster itself. Many times, the hospitals are involved and may sustain some type of damage or interruption of services, supplies, or personnel. It is critical to establish which hospital buildings are useable, to plan the use of available medical care. Because of the critical need for health care resources after a natural disaster, these facilities will be closed, in whole or part, only as a last resort and only if a threat to life safety exists. OSHPD's intent is to keep facilities open, but open safely.

California can expect earthquakes in the future. Standard procedures between agencies and counties have been established and a communication database for sharing information is in place. Every disaster is unique with its own set of problems. The OSHPD Emergency Response Plan provides a template for a course of action that will be fine-tuned to meet the needs of the next disaster when it occurs.


INSPECTED

LAWFUL OCCUPANCY PERMITTED

Inspected Exterior Only

Inspected Exterior and Interior

Inspector Comments:

Date Time

Facility Name and Address:

This facility was inspected under emergency conditions for:

Safety Evaluation Team

Do Not Remove, Alter, or Cover this Placard For 90 Days Unless Authorized by OSHPD

Health & Safety Code

Green Placard


RESTRICTED USE

Caution: This structure has been inspected and found to be damaged as described below:

Entry, occupancy, and lawful use are restricted as indicated below:

(Caution: Aftershocks since inspection may increase damage and risk.)

Date Time

Facility Name and Address:

This facility was inspected under emergency conditions for:

Safety Evaluation Team

Do Not Remove, Alter, or Cover this Placard Until Authorized by OSHPD

Health & Safety Code

Yellow Placard


UNSAFE

DO NOT ENTER OR OCCUPY

(THIS PLACARD IS NOT A DEMOLITION ORDER)

This structure has been inspected, found to be seriously damaged and is unsafe to occupy, as described below:

Do not enter, except as specifically authorized in writing by jurisdiction. Entry may result in death or injury.

Date Time

Facility Name and Address:

This facility was inspected under emergency conditions for:

Safety Evaluation Team

Do Not Remove, Alter, or Cover this Placard Until Authorized by OSHPD

Health & Safety Code

Red Placard

OSHPD Pilot Project on Immunizations

Reaching out to meet the health care of California's Children

An Alameda County Paramedic trained to give immunizations to local residents

A pilot project, sponsored by the Alameda County Emergency Medical Services District (Alameda) and monitored by the Office of Statewide Health Planning and Development, seeks to increase the immunization rate among children in Alameda County, while teaching new skills to Emergency Medical Technicians/Paramedics. This Immunization Pilot Project trains paramedics to give children immunizations in non-traditional locations such as fire stations, schools, and day care centers.

Through this project, Alameda will be able to test and demonstrate that paramedics can administer selected immunizations at outreach clinics sponsored by the Fire Department without compromising patient safety and current standards of practice. A total of 15 paramedics will participate in the project, learning a new skill normally performed by other health care personnel.

Alameda asserts that their County is striving to maximize immunization opportunities in order to decrease immunization-preventable diseases. In a 1996 retrospective study of kindergarten health records, only 66.4% of the children in Alameda County were up-to-date on their vaccinations by age two. While this is higher than the statewide average of 57 percent, it is far below the nationwide target of a 90 percent immunization rate for two-year olds by the year 2000. Alameda hopes to further lessen the gap through this project.

Low immunization rates are not the result of any one factor, but a combination of many. Some of the barriers include cost of the vaccines, access to health facilities, and education regarding the importance of receiving vaccinations at the recommended intervals.

It is hoped that this pilot project will help to improve the vaccination rates in this area and be viewed as another way to further decrease immunization-preventable diseases in California and the nation.

The Office will evaluate and gather data on the expanded roles for Emergency Medical Technicians/Paramedics. Its determinations will help decide whether this pilot project will become permanent. For more information, please contact Ms. Gloria J. Robertson, Manager of Health Manpower Pilot Projects program, Primary Care Resources and Community Development Division, at (916) 654-1837.

Health Manpower Pilot Projects

Looking at Innovations in health care

The Health Manpower Pilot Project program, established by the Legislature during the early 1970's, provides an avenue for testing and evaluating innovations in the roles of health personnel in the delivery of health care. Steps in the Pilot Project process include:

- Submission of an application to OSHPD for feasibility review.
- Consideration of the application by the appropriate review board and commission.
- Solicitation of public comment on the pilot project through public meetings/ hearings.
- Final review/approval by the Office's Director.
- Monitoring of approved project to affirm adherence to State objectives.
- Collection of data as required in regulations.
- Final evaluation of the project upon its completion.

The program has made significant contributions to California's health care delivery system by providing the legal framework for testing new scope-of-practice concepts. It has accomplished this by collecting and analyzing the data generated by pilot projects and making recommendations to policy makers and the Legislature based on the pilot project. A sampling of some of our successful past pilot projects includes:

Nurse Practitioner Training Program – the Project provided for a training program to expand the role and scope of practice for registered nurses as nurse practitioners under the provision for "Standardized Procedure". The Nurse Practices Act was amended in 1975 to allow for the expanded role.

Dental Hygiene Access to Care – the Project was to determine whether registered dental hygienists could practice safely and effectively in an independent practice setting. In 1997, the Dental Practice Act was amended to establish a registered dental hygienist in alternative practice as a new category of dental auxiliary.

Questions or inquiries on the Pilot Project Program may be directed to the program's manager, Ms. Gloria J. Robertson, at (916) 654-1837.

California's Look Into Cesarean Childbirth

Two studies underway by OSHPD

In the mid-1980s, California had a dramatic increase in cesarean section childbirth, causing concerns that the procedure was being utilized too frequently and perhaps unnecessarily. While more recent statistics are showing a slight trend toward decreased cesarean childbirth, the Office of Statewide Health Planning and Development is conducting two studies on this issue. One will focus on obstetrical practices to determine the most common reasons for cesarean section. The other study will determine if there are meaningful differences in clinical processes or administrative structures between hospitals with high and low cesarean rates.

Cesarean childbirth is a surgical procedure to deliver a baby through an incision in the abdomen. A major operation, each cesarean actually involves a series of separate incisions in the mother — the skin, underlying muscles and abdomen are opened first and then the uterus is opened allowing removal of the infant. There are two main types of cesarean operations, each named according to the location and direction of the uterine incision: 1) cervical—a transverse (horizontal) or vertical incision in the lower uterus, and 2) classical—a vertical incision in the main body of the uterus. Today, the low transverse cervical incision is used almost exclusively. It has the lowest incidence of hemorrhage during surgery as well as the least chance of rupturing in later pregnancies. Sometimes, because of fetal size (very large or very small) or position problems (breech or transverse), a low vertical cesarean may be performed.

"The California Health Policy and Data Advisory Commission has formed a Workgroup, comprised of some of the nations leading experts on cesarean delivery, to advise the Office and the research team."

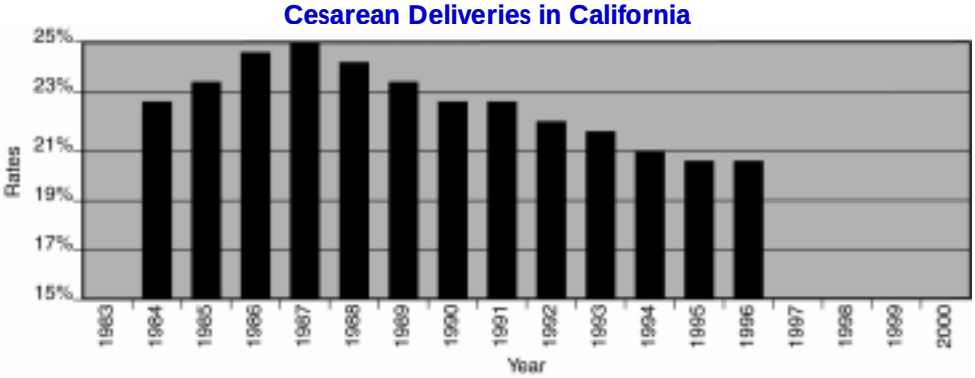
There are certain times when conditions in the mother or infant make cesarean delivery the method of first choice. By providing an alternate route of delivery, the procedure offers great benefit in situations when a vaginal delivery carries a high risk of complications or death. While maternal death during childbirth is extremely uncommon, the death rates associated with cesarean births are higher than with vaginal births. Because major surgery is involved in cesarean sections, the chance of infection and complication is much greater. National figures, in fact, show cesarean birth carries up to four times the risk of death compared to a vaginal delivery.

From 1970 to 1980, the number of cesareans in the U.S. more than tripled, increasing from five percent of all births to 16.5 percent. In some localities the rate is even

higher. This startling increase became a matter of national concern, and in 1991, the US Department of Health and Human Services established public health goals for the nation and published them in *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. The goal for cesarean delivery is a national average of 15 percent.

Although California has adopted these goals and is making efforts to decrease the use of cesarean deliveries, the following graph shows that it is highly unlikely that California will meet the 15 percent target by the year 2000.

Cesarean Deliveries in California



However, it is possible that, over the next several years, further decline in surgical delivery rates might be encouraged by providing the state's hospitals, physicians, and nurse-midwives with objective information generated from a carefully constructed study of the factors associated with cesarean rates in California.

The Office of Statewide Health Planning and Development, through its Health Policy and Planning Division, is collaborating with the Center for Health Services Research in Primary Care at the University of California, Davis, to conduct two projects focussing on cesarean deliveries in California. The California Health Policy and Data Advisory Commission has formed a Workgroup, comprised of some of the nations leading experts on cesarean delivery, to advise the Office and the research team.

Do hospitals with low C-section rates have different processes of care and administrative structures than hospitals with high rates? What are the opinions and beliefs of the physicians and nurse-midwives who deliver babies in California's hospitals? Can some of these people be identified as being educationally influential? These are some of the questions the Office is hoping to address through the two projects:

The Processes of Care Project will attempt to ascertain if hospitals with low rates of surgical delivery have different processes of care and administrative structures than hospitals with high rates of surgical delivery.

Data will be abstracted from copies of about 2500 medical records, which were created from deliveries during 1992/93 and 1996, from a sample of approximately 45 hospitals. In addition, publicly available data about the selected hospitals will be analyzed.

This information will be analyzed to determine if there are meaningful differences in clinical processes or administrative structures between hospitals with high and low cesarean rates. The most currently available data, 1996 data, will be used to determine if these differences are maintained across time.

The Opinion Leader Project will describe the obstetric opinions and beliefs of the physicians and nurse-midwives who deliver babies in California's hospitals. It will also try to

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Coronary Artery Bypass Graft Outcomes Reporting Program

A public-private partnership to improve quality of care for California

The California CABG Outcomes Reporting Program collects and reports coronary artery bypass graft (CABG) data from 95 of the 120 hospitals in California that perform this procedure. The project is jointly sponsored by the Pacific Business Group on Health (PBGH), and the Office of Statewide Health Planning and Development in a unique public-private partnership to improve the quality of care for California's citizens.

The CABG Outcomes Reporting Program is similar to OSHPD's California Hospital Outcomes Projects (CHOP), since both programs provide a risk-adjusted evaluation of hospital quality. While CHOP and the CABG program seek similar goals, there are several interesting comparisons between them. For example:

- One is mandated by law, one seeks voluntary participation from hospitals;
- One is based on administratively collected patient discharge data, one collects specific clinical data;
- One is run by OSHPD alone, one is operated as a public-private partnership distinguished by its collaboration between OSHPD, PBGH and the California Society of Thoracic Surgeons;
- Both are risk-adjusted and report at the hospital level.

Surgeons and hospitals are not alone in their need for good information on the quality of care. The State of California is interested in improving quality-of-care received by its citizens, while large employers who purchase health care services for their employees are increasingly interested in knowing they are receiving value for their dollar. Currently, quality-of-care information is difficult to find, so most purchasing decisions are determined by price alone. Reporting of hospital outcomes data has begun to help close the gap in health care purchasing information. The goal is to give hospitals the data they need to compare their performance against their peers, and to stimulate a dialogue among hospitals to share best practices. A publicly available risk-adjusted report should be available by mid 1999.

Coronary artery bypass surgery is the most common "open-heart" surgery done today. In 1996, more than 25,000 CABG procedures were performed in approximately 120 hospitals across the state. The coronary arteries are blood vessels on the surface of the heart that provide blood to the heart muscle itself. When one of the coronary arteries is blocked or narrowed, the blood supply to the heart muscle is reduced. This can lead to severe chest pain that can restrict one's ability to perform normal activities or can cause a heart attack. In severe cases, it can be life threatening. In this surgery, a substitute vessel (known as a graft) is attached onto the surface of the heart to create a new path for blood to bypass a blocked artery. The arteries that are being bypassed

are about the size of spaghetti. If you hear that someone had "triple bypass" surgery, this means that three new paths were created. No surgical procedure is completely safe, but overall about 97% of all patients survive the operation.

The average charge for such a procedure was roughly $75,000. CABG surgery was selected for review because it is a costly operation that is frequently performed. For some hospitals, only births comprised a larger proportion of their revenue stream. Operative mortality, i.e. did the patient survive the procedure, is an important outcome measure for CABG surgery and was selected as a measure of hospital quality for CABG surgeries because it can be reliably measured and affords comparability.

A key characteristic of the CABG program is that hospital participation is voluntary, and this drives most of the other decisions for the program. There is no charge to the hospitals to participate. Hospitals will only supply the labor to collect and submit data. Approximately 40 data elements are collected. These elements include patient history, urgency of the procedure, age and sex of the patient and in-house surgical mortality associated with the CABG.

Once the data are collected and validated, they will be entered into a publicly accessible database, just like any other data collected by a state agency. Hospitals submitting data will have a chance to review the data and project staff will work with hospitals to make corrections or validations prior to public release. When hospitals pledge to participate, we ask that they send the people who will collect the data to a training session that the CABG Outcomes Reporting Program runs, in order to standardize data definitions and collection techniques. Such a training session was held in Oakland in June, and was videotaped. In addition, project staff are now making plans to do "mini-audits" at a subset of participating hospitals to spot-check variations in the way data are collected.

"The goal is to give hospitals the data they need to compare their performance against their peers, and to stimulate a dialogue among hospitals to share best practices."

There are three main benefactors from the collection of this data. They are: Hospitals — to stimulate and facilitate quality improvements at individual institutions and statewide; Purchasers of care — to assess provider performance and make quality-based purchasing decisions; and Consumers — to make more informed decisions about options for care and where to receive it.

The intention is to produce risk-adjusted mortality rates on an annual basis, but the real goal is to use the data to stimulate a dialog among hospitals to share best practices. Currently, there are no data available to California hospitals that allow them to compare risk-adjusted performance for CABGs. As we have seen in other states, simply making these data available can help identify correctable problems that will lead to improved clinical outcomes.

Facility Project Accounting

A new automated accounting system for construction projects

As required by law, when health facilities submit plans for construction or remodeling of their facilities, a monetary assessment is made to cover the costs of staff time to review the plans and provide oversight and inspection services during construction. In the past, the Facilities Development Division (FDD) had the responsibility of collecting these revenues, but it was a job more suitable to the Office's Administration Division.

The new accounting system replaces an old mainframe program that was inadequate and inefficient. The accounting and invoice work has been transferred to the Office's Administration Division. The Facilities Development Division logs all cost records of the projects into a logbook, which is downloaded into the accounting database. The Administration Division then generates invoices that are sent to the health facilities. The invoices are generated at the very beginning of the project and continue throughout the life of the project, as the plan review work and construction inspections are accomplished.

The new system also allows health facilities the option of participating in a prepayment plan. Currently, there are four facilities set up for prepayments, including Kaiser South, the University of California at San Francisco, Stanford Health Care, and Covenant Care. These clients deposit funds into an account that is debited as invoices are generated.

The benefits of these changes are many: invoices are sent out in a more timely manner, hospitals have a hard copy record to track all of the fees due, and projects are paid up as they go.

"The new system also allows health facilities the option of participating in a prepayment plan."

Cal-Mortgage Program

Opportunites for California Health Care Facilities

Center for AIDS Research, Education, and Services (CARES) of Sacramento

Many types of health care facilities across California are eligible for assistance by the Cal-Mortgage Program. This assistance is in the form of insurance for certain types of loans taken out by the borrower — loans for construction, expansion, modernization, acquisition or renovation. Following are two recent projects for which Cal-Mortgage has insured loans.

The **Center for AIDS Research, Education and Services (CARES)** in Sacramento, California, is the largest provider of services for people with AIDS and HIV in the Sacramento Metropolitan Area and one of the few freestanding private centers of its kind in the country. In April 1998, OSHPD's Cal-Mortgage Loan Insurance Program insured a loan in the amount of $3,330,000 in order for CARES to purchase a 24,374 square foot building located in midtown Sacramento.

This nonprofit, public benefit corporation has been providing medical and social services to HIV positive persons since 1988. Since CARES' opening, it has served over 3,500 individuals and has a current caseload of over 1,200 individuals, with an average increase of approximately 25 new cases per month. Diagnosed and reported cases of AIDS in Sacramento as of July 2, 1998, totaled 2,588. It is estimated that for every known case of AIDS, there is one unknown and untreated HIV infected person. Epidemiologists believe there are additional 3,000 HIV positive individuals in the Sacramento Metropolitan Area.

Currently there is no cure for AIDS, but the changes in treatment are requiring more medical services. Recent changes in the medical treatment of HIV have minimized the number of deaths and extended the lives of HIV patients. But those treatments involve complex drug therapies, which not all patients are able to follow, and require increased monitoring, such as more frequent visits to a doctor. While surveys indicate as many as 500

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individuals have received care through private physicians, CARES, through its partnership with UC Davis and the County of Sacramento, provides the majority of these medical services to the known AIDS/HIV population in Sacramento.

CARES receives the support of many major health care organizations in its area, including Sutter Health, Mercy Healthcare of Sacramento, UC Davis Medical Center, and Kaiser Permanente. Currently, each of these health care organizations contributes $100,000 annually to help CARES meet the needs of AIDS/HIV patients in the Sacramento area.

CARES believes in working in partnership with other organizations. It contracts with the UC Davis Medical Center for physicians and has established an on-site pharmacy as a collaborative effort with the County of Sacramento. Also, in partnership with Sacramento County, funds have been approved for the purchase of equipment to pay for an oral hygiene and dental care program for CARES clients.

CARES new building has two-stories with a basement. It occupies the first floor and the basement, and intends to lease the second floor spaces to other nonprofit health care corporations, until they need to expand into the space.

The CARES project was financed with tax exempt bonds, issued by the City of Sacramento, for a term of 25 years. The Cal-Mortgage staff will continue monitoring this project for the life of the loan.

The **Southern California Drug and Alcohol Programs, Inc. (So. Cal)**, with several sites in Los Angeles and Orange Counties, serves clients with alcohol and/or drug abuse problems. OSHPD's Cal-Mortgage Loan Insurance Program guaranteed a $5,967,722 loan to So. Cal on May 12, 1997. This loan provided funds to purchase an administrative building in Downey and to purchase an eight-unit multi-family building in Bellflower. The new residential property added 40 beds of capacity to a current program that serves addicted women and their children who are escaping a violent domestic environment. So. Cal now has a capacity of 400 residential beds.

This nonprofit, public benefit corporation has been providing assistance to clients with alcohol and/or drug abuse problems since 1972. So. Cal's corporation is highly diversified and provides nine residential programs (serving 2,000 clients) and 11 outpatient programs (serving 3,000 clients) in Los Angeles and Orange Counties. It is the largest provider of addiction recovery services in its 100 square mile service area.

"The new residential property added 40 beds of capacity to a current program that serves addicted women and their children who are escaping a violent domestic environment ."

Southern California Drug and Alcohol programs (So. Cal.)

The population in So. Cal's Primary Service Area (PSA) is growing at a rate of two percent per year. Two to eight percent of these individuals will need residential and/or outpatient addiction recovery services each year. There is little or no direct competition in this service area because of So. Cal's size and the diversity of services it offers.

So. Cal is an important community asset. A May 1997 study entitled Substance Abuse Needs in California's Welfare Population draws the correlation between substance abuse treatment and *welfare to work* success. The growth of Drug Court programs and programs that serve addicted women and their children make So. Cal an indispensable necessity in its community.

In the past, a significant barrier to the transitioning from *welfare to work* has been the high incidence of substance abuse among welfare recipients. Studies have shown that the largest percentage of welfare recipients are women with children and, among those, 27% are substance abusers. Participants in *welfare to work*programs increase the demand for addiction recovery services and require more intensive and specialized services, such as programs tailored for women and children. Economically, studies show that for every $1 spent on addiction recovery programs, $7 is saved in costs associated with unemployment, crime, use of publicly-funded medical services, and out-of-home placements.

An experienced management team runs So. Cal. Their ranks include individuals with diverse professional backgrounds in areas such as law, business, medicine, labor relations and substance abuse. Their tenures range from one to twenty-five years, with a majority serving for over seven years.

So. Cal is fiscally sound. It receives 65% of its revenues from government sources, with the remaining 35% coming from client fees and private sector contracts, such as Kaiser and other insurance providers. Over the past 25 years, So. Cal has shown the ability to adapt to periodic revenue reductions by both decreasing expenses and acquiring other private sources of revenue through the development of new programs for which there is a demand.

The Cal-Mortgage Loan Insurance for So. Cal is for a term of 25 years, and staff will continue to monitor the project throughout the life of the loan.

Song-Brown Family Physician Training Program

OSHPD Commemorates 25 Years

Dr. Werdegar welcomes attendees to the Song-Brown panel discussions and commemoration

Health Manpower Policy Commission Chairperson Ransom Buck Turner is presented with a Senate Resolution for his exemplary service to the Song-Brown program

Virginia Fowkes, Director of the Physician Assistant program at Stanford University Medical Center talks about the importance of training family health care teams

The Song-Brown Family Physician Training Program celebrated its 25th anniversary this year with a commemoration, held in Millbrae, California, on October 6. The event included panel discussions lead by Director David Werdegar and William Burnett, followed by an evening reception and awards dinner.

Topics covered during the panel discussions focused on:

•Caring for the underserved - with guest speakers Patrick T. Dowling, MD, MPH, Chair, Department of Family Medicine, Harbor-UCLA Medical Center; Susan Y. Melvin, DO, Director of Family Practice Residency Program, Long Beach Memorial Medical Center; and Ludlow B. Creary, MD, MPH, Chair, Family Practice Residency Program, King/Drew Medical Center.

•Training family health care teams – with guest speakers Virginia Fowkes, Director of the Physician Assistant Program at Stanford University Medical Center; Robert C. Davidson, MD, MPH, Chair, Department of Family Medicine, University of California, Davis; Les Howard, PA, Physician Assistant Training Program, Riverside Community College; and Janet Mentink, Director of the Family Nurse Practitioner/Physician Assistant Program, UC Davis Medical Center.

•The new environment of managed care – with guest speakers Hector Flores, MD, Co-Director, Family Practice Residency Program, White Memorial Medical Center; John E. Midtling, MD, MS, Associate Dean and Head, Department of Family and Community Medicine, University of Illinois Medical School in Rockford; and Perry A. Pugno, MD, MPH, Director of Family Practice Residency Program, Mercy Healthcare.

Former Assemblyman Phillip L. Isenberg gave the keynote address. With great wit and wisdom, he entertained and educated the 120 attendees — highlighting the past accomplishments of the Song-Brown program and looking to the future of primary care policies and politics.

Special presentations were provided to those who have contributed to the success of the Song-Brown program. Awards were given to Ransom Buck Turner, MD, Chairman of the California Health Manpower Policy Commission; and to William Burnett, MA, Helen Lowry, and Rosa Baltzell of the OSHPD Primary Care Resources and Community Development Division. An award was given to Dave Werdegar, by the Health Manpower Policy Commission, for his efforts in support of the Song-Brown program.

Keynote speaker Former Assemblyman Phillip L. Isenberg shared his thoughts on health policy, politics and primary care

Dr. Patrick T. Dowling shares his insight into serving the underserved during one of the Song-Brown panel discussions

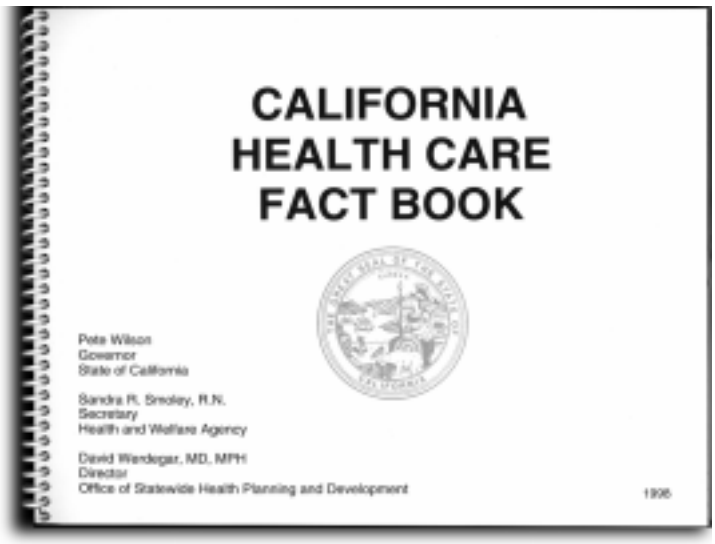
WHAT IS THE SONG-BROWN FAMILY PHYSICIAN TRAINING PROGRAM?

The Song-Brown Family Physician Training program has provided financial support to training programs for family practice residents, primary care physician assistants and family nurse practitioners for the past 25 years. A principal goal of the program is to increase access to primary care in those California communities most in need of these services. Song-Brown has had a remarkable record of success in preparing young health professionals for service to families throughout the State.

Information on the Song-Brown program may be obtained from Susan Brazil, Primary Care Resources and Community Development Division, at (916) 654-2091.

California Health Care Fact Book

A Snapshot of California's health and health care system



Californians are now being asked to make informed decisions about their own health care and about health care issues in the public policy arena. In order to make knowledgeable decisions, one must understand the basic facts of health care and the issues we face, both individually and collectively as members of the larger community. The California Health Care Fact Book was compiled to assist in this learning process. The Fact Book was published by OSHPD, with support from the Robert Wood Johnson Foundation.

The Fact Book contains information collected from a number of State departments and private organizations. It provides a snapshot of California's population, health providers, and health care needs. Specifically, the book provides information about:

- California's population trends in terms of ethnic origin, age, geographic distribution;
- Annual expenditures for health-related services in California, health insurance coverage, the MediCal program, and HMOs.
- California's health care providers and facilities;
- California statistics for pregnancy-related care, cancer, heart disease, AIDS, and other conditions, as well as for the most common causes of hospitalization, major causes of death, and prevalence of mental health and substance abuse problems;
- Issues likely to figure prominently in discussions of health care in the near future.

Copies of the California Health Care Fact Book are available in hard cover and on the Internet. Please call the Health Care Information Resource Center at (916) 322-2814 to order your copy.

Valley Children's Hospital

A focus on Collaboration

By Chris Murray, Regional Manager
Central Region, Facilities Developmet Division

Valley Children's Hospital in Fresno
Photograph by Keith Seaman

One of the largest divisions within the Office of Statewide Health Planning and Development, the Facilities Development Division, provides for the review of plans and oversight of the construction of health facilities in California. Here is one instance where a coordinated effort by the Office of Statewide Health Planning and Development and other state and local agencies made the difference for one facility that had a dream of opening its doors on September 1, 1998.

Valley Children's Hospital is now complete and opened its doors on September 1, 1998! The facility is located in Madera County, adjacent to Fresno, and is an 860,000 square foot complex with 201 licensed beds. Costing an estimated $150 million, it will serve the health care needs of children in the Central Valley. One of the unique aspects of this project was how some of the final fire and life safety issues were resolved.

Lorin Nyer is the Fire and Life Safety Officer (FLSO) and Brian Coppock is the Area Compliance Officer (ACO) for Madera County, both of whom have done a remarkable job providing construction observation for the facility. Several months ago, the hospital began to communicate to our office their schedule for completion and subsequent occupancy of the building. The schedule was optimistic, and we realized it would be tremendously difficult for them to achieve their goals, but we assured them that we would do all we could to assist. Lorin was especially helpful in assisting them with the development of a schedule that would allow time for her to review all of the key elements of the fire and life safety system and still meet the proposed schedule.

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Due to the complexity of finalizing the mechanical and fire alarm systems, the completion schedule moved from optimistic to near impossibility, since testing many of the fire and life safety devices were dependent on these system being operational. An idea was proposed for a whole team of people to converge on the facility together to inspect certain elements that are best reviewed all at once. Instead of one individual moving through the facility and taking many weeks, Lorin Neyer could oversee teams of individuals that would accomplish the required activities in a relatively short time. With that accomplished, other systems could be inspected that are best done by an individual.

The team that assembled was a mixture of plan review and field staff as well as individuals from other agencies. The California State Fire Marshal, Madera County Fire Department and the Visalia Fire Department all contributed personnel to the effort. OSHPD was represented by architects, mechanical and electrical engineers, area compliance officers, fire and life safety officers, and even a Regional Supervisor.

The full team assembled for two days of action on July 13. Each individual from a "review agency" was paired with an individual from the construction team who was familiar with the building layout. This group included folks from the construction company, inspection team and the design professionals.

At the end of the second day, the lists of corrections were gathered from all of those providing construction oversight. In the course of two days, the team was able to accomplish many weeks of work. This set the stage for a special effort by Kevin Moore, FLSO from the North Region, who after 3 days of focused effort, developed a list of corrections on the overall fire alarm system.

All this reminds me of the old Oregonian expression "Many hands make a huge mess." No, maybe it was "Too many cooks make light work." Oh well, I can't remember the exact phrase, but the bottom line is whether in California or Oregon, when you get a bunch of people organized and cooperating, wonderful things can happen.

I want to express thanks to all of the individuals that were willing to invest in this effort. Our office goal is to provide excellent service to our clients, *efficiently and flexibly*, and the type of effort that was invested in this project is a tremendous example of that.

There was one other individual who was not at the big inspection party on July 13 that I should mention. Matt Stockton, Area Compliance Officer, has put in so many miles from his home in Rohnert Park to the facility that rumor has it he has counted the number of power poles on that stretch of highway. Thanks for your help Matt! Lorin, Brian and Matt have work diligently to get the project to the place where all the rest of us could come in and help with some finishing touches. We all appreciate the dedication and professionalism that helped a new children's hospital provide state-of-the-art service to the Central Valley.

Legislative Update

Health Data Improvement
SB 1973 (Maddy, R-Fresno)

The Office of Statewide Health Planning and Development sponsored this bill which requires the collection of information to support informed decisions about access, cost and quality of health care in California.

SB 1973 was developed in response to a comprehensive two-year study of California's health data collection system. This study included participation and input from health care providers, purchasers, organized labor, consumers, insurers, managed care organizations, and government agencies. The purpose of the study was to ensure that as we move into the 21st century, timely, accurate and relevant information will be available to decision makers concerned about the health care in California.

Specifically, the bill will:

- Make existing inpatient hospital data available to the public a minimum of eight months earlier than under the current system.
- Provide new information on outpatient surgeries, which represent 60 percent of all surgeries performed in California.
- Provide new information about the ten million patients treated in emergency rooms each year.
- Evaluate the potential for combining, streamlining or eliminating redundant or unnecessary hospital reporting requirements.

The provision of broader and more timely health care information will support efforts to achieve cost-containment, health care access, and quality assurance objectives, which will help to improve the health of all Californians.

Bill Status: SB 1973 was signed by the Governor, Chapter 735, Statutes of 1998.

Notification Requirements for Skilled Nursing and Intermediate Care Facilities
AB 2747 (Alquist, D-Santa Clara)

Also sponsored by the Office, this bill repeals the existing law that requires skilled nursing and intermediate care facility owners to notify the Office of their intention to increase bed capacity. This legislation will result in improved service and reduced costs to these health facilities by eliminating unnecessary delays in the issuance of building permits. Additionally, the bill will eliminate a requirement for data that is no longer used by the Office, the facilities or the general public.

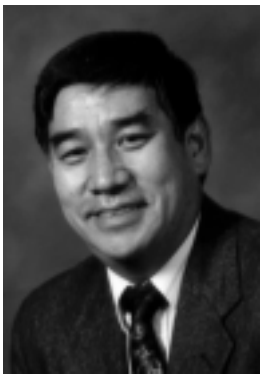
The bill also makes technical amendments to the Hospital Facility Seismic Safety Act which eliminate unnecessary and outdated language.

Bill Status: AB 2747 was signed by the Governor, Chapter 369, Statutes of 1998.

Appointments

New Members to the Health Manpower Policy Commission

The primary function of the Health Manpower Policy Commission is to review and make recommendations regarding the use of the Office of Statewide Health Planning and Development funds provided to advance primary medical care education. Over $5 million will be distributed this year through the Song-Brown program established 25 years ago.



JIMMY HIDEO HARA, M.D.

Jimmy Hideo Hara, M.D. is regional director of graduate medical education for Southern California Kaiser Permanente and director of graduate and undergraduate medical education for Kaiser Los Angeles Medical Center. He has served as a family physician for Southern California Kaiser Permanente since 1974. Dr. Hara is also the residency program director and assistant chief of service for the Kaiser Los Angeles Department of Family Practice, as well as an associate clinical professor and executive committee member for the University of California, Los Angeles Multicampus Department of Family Medicine. He is a fellow of the American Academy of Family Physicians, and member of the Society of Teachers of Family Medicine and the American Association of Family Practice Residency Directors. Dr. Hara earned his bachelor's degree from the University of California, Los Angeles in 1966 and a medical degree from the University of California, San Francisco in 1970.

DEBORAH A. RICE, R.N.

Deborah A. Rice, R.N. has served as a family nurse practitioner in Palmdale since 1988. She has also served as a nurse practitioner for the University of California, Los Angeles since 1992 and for Dr. Ric Garrison since 1988. Previously, she was a registered nurse and nurse practitioner for the Antelope Valley Medical Center. Ms. Rice was recently elected to the board of directors of the Antelope Valley Health Care District. She is a member of the American Association of Nurses, American Association of Critical Care Nurses, California Coalition of Nurse Practitioners and the UCLA Alumni Association. She earned a bachelor's degree in nursing from the California State University, Dominguez Hills in 1986 and a master's degree in nursing from the University of California, Los Angeles in 1988.

MARY ELINA FERRIS, M.D.

Mary Elina Ferris, M.D. is currently the medical director for quality improvement programs with California Medical Review, Inc., a position she has held since 1995. She also owns a private medical practice in Santa Barbara. Dr. Ferris has served as associate clinical professor of family medicine at Loma Linda University, as a clinical associate professor of family medicine at the University of Southern California, predoctoral director, residency consultant and educational coordinator at the University of Southern California School of Medicine, Department of Family Medicine, program director for the family practice residency program at Glendale Adventist Medical Center, and faculty and geriatric education coordinator for the family practice residency program at Santa Monica Medical Center. Dr. Ferris is a member of the American Health Quality Association, California Medical Association, California Academy of Family Physicians, Los Angeles County Medical Association, Santa Barbara County Medical Association, American Academy of Family Physicians, Society of Teachers of Family Medicine and the California Primary Care Consortium. She earned a bachelor's degree in biology from John Hopkins University in 1974, a master's degree in biology from the University of California, Santa Barbara in 1976, and medical degree from the University of California, San Francisco in 1980. She earned a second master's degree, in education, from USC in 1990.

ROLF D. KNAPP, D.O.

Rolf D. Knapp, D.O. has been in practice as an osteopathic family physician since 1989. He completed his residency at Pacific Hospital of Long Beach in 1989 and was an intern with Normandy Osteopathic Hospitals in Saint Louis, Missouri, from 1987 to 1988. Dr. Knapp is president of the D.O. Section of the Western University of Health Sciences Alumni Association and a member of the board of directors of the Osteopathic Physicians and Surgeons of California. He is also a member of American Academy of Family Physicians, American College of Osteopathic Family Physicians, American Osteopathic Association, Orange County Osteopathic Medical Association, and the Christian Medical and Dental Society. Dr. Knapp earned his bachelor's degree from Pomona College in 1983 and a doctorate of osteopathic medicine from the Western University of Health Science College of Osteopathic Medicine of the Pacific in 1987.

New Publications

What's new for you to view!

The Office maintains several health facility data programs related to hospitals, long-term care facilities, licensed clinics, home health agencies, and hospices. In addition to the products listed below, the Healthcare Information Division is exploring new products to make available through its Resource Center.

Hospital Annual Financial Data, Report Periods Ending 6/30/96-6/29/97

This product presents data from the Hospital Annual Financial and Utilization Data Program, and consists of financial statements and supporting revenue and expense schedules, utilization statistics, and other facility information. It is available in print, as an electronic database on CD-ROM, or magnetic tape.

Hospital Annual Selected Data, Calendar Year 1997

This product presents data selected from the Hospital Annual Financial and Utilization Data Program, and consists of hospital demographics, assets, liabilities, revenue, expense, utilization and labor information. It is available at no charge for download from the Office's Internet site.

Licensed Services and Utilization Data, Annual Utilization Report of Hospitals - 1997

This product presents data from the Hospital Utilization Data Program and consists of individual facility information. It also contains health facility information, inpatient bed utilization, and data on hospice programs and long-term care services. It is available now for purchase on diskette, or for download from the Office's Internet site at no charge.

Licensed Services and Utilization Data, Annual Utilization Report of Hospitals – Statewide Summary Trend Data, 1988-1997

This product presents ten years of selected, aggregated data from the Hospital Utilization Data Program, and consists of general facility information, patient census information, type of care and utilization data. This data file is available now for download at no charge from the Office's Internet site.

Quarterly Hospital Financial Data, 2nd Quarter 1998

This publication presents data from the Hospital Quarterly Financial and Utilization Data Program, and consists of a summary financial statement, utilization statistics, and other facility information. It is available in print, as an electronic database on CD-ROM, or magnetic tape.

Hospital Quarterly Data Trends, 3rd Quarter 1997

This mini-publication presents data from the Hospital Quarterly Financial and Utilization Data Program, and consists of narrative, charts, and a data summary. It is available at no charge as a download from the Office's Internet site. A Data Trends publication is also available for 1st and 2nd Quarter 1997.

Long-term Care Facility Financial Data, Report Periods Ending 12/31/96-12/30/97

This publication presents data from the Long-term Care Facility Financial Data Program

and consists of financial statements and supporting revenue and expense schedules, utilization statistics, and other facility information. It is available in print, as an electronic database on CD-ROM, or magnetic tape.

Long-term Care Facility Selected Data, Calendar Year 1997

This product presents data selected from the Long-term Care Facility Financial Data Program, and consists of facility demographics, assets, liability, revenue and expense, utilization and labor information. It is available at no charge for download from the Office's Internet site.

Licensed Services and Utilization Data, Annual Utilization Report of Long-term Care Facilities - 1997

This product presents data from the Long-term Care Utilization Data Program, and consists of individual facility information such as general facility information, patient census information, patient demographics, type of care and utilization data. It will be available in January 1999 for purchase on diskette, or for download from the Office's Internet site at no charge.

Licensed Services and Utilization Data, Annual Utilization Report of Long-term Care Facilities – Statewide Summary Trend Data, 1988-1997

This product presents ten years of selected, aggregated data from the Long-term Care Utilization Data Program, and consists of general facility information, patient census information, type of care and utilization data. It will be available in January 1999 for download from the Office's Internet site at no charge.

Licensed Services and Utilization Data, Annual Utilization Report of Home Health Agencies & Hospices- 1997

This product presents data from the Home Health and Hospice Utilization Data Program. This data file contains individual facility information which includes home health agencies and hospices by ownership type, number of visits by principal diagnosis, and number of visits by reimbursement source. It will be available in March 1999 for download at no charge from the Office's Internet site.

Licensed Services and Utilization Data, Annual Utilization Report of Home Health Agencies – Statewide Summary Trend Data, 1994-1997

This product presents four years of data from the Home Health Utilization Data Program. It will be available in March 1999 for download from the Office's Internet site. Included are selected data elements such as number of agencies reporting by ownership type, unduplicated number of patients, visits by principal diagnosis and number of visits by reimbursement source.

Licensed Services and Utilization Data, Annual Utilization Report of Primary Care Clinics -1997

This product presents data from the Primary Care Clinic Utilization program and consists of individual facility information such as number of patients and encounters; patients by age, gender, race and ethnicity; charges and revenue by payer source. This data file will be available in February 1999 for download at no charge from the Office's Internet site.

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Licensed Services and Utilization Data, Annual Utilization Report of Primary Care Clinics – Statewide Summary Trend Data, 1991-1997

This product presents seven years of data from the Primary Care Clinic Utilization program and consists of selected data elements aggregated to the statewide, including encounters by type of service, revenue collected by source and unduplicated number of patients. This data file will be available in March 1999 for download at no charge from the Office's Internet site.

Licensed Services and Utilization Data, Annual Utilization Report of Specialty Care Clinics – 1997

This product will consist of individual facility information on alternative birth centers, and psychology, surgical, chronic dialysis and rehabilitation clinics. The information includes number of patients and encounters, number of operating rooms (of surgical clinics), and major capital expenditures. This data file will be available in February 1999 for download at no charge from the Office's Internet site.

Licensed Services and Utilization Data, Annual Utilization Report of Hospices-Statewide Summary Trend Data 1996-1997

This data product contains two years of selected aggregate data for all freestanding hospices as well as hospices included within home health agencies. Information includes number of patients by admission source, visits by staff, visits by primary condition, patients by race, gender and age, patient days by payer and average visits of discharged patients by primary condition. This data file will be available in March 1999 for download at no charge from the Office's Internet site.

What's in the Construction Pipeline?

A listing of Facilities Development Division's larger construction/ remodel projects as of September 24, 1998

Facility	Cost
St. John's Hospital	$ 138,233,532
Valley Children's Hospital	$ 95,808,100
Riverside Co. Regional Med. Center	$ 92,499,300
University of California Davis	$ 78,642,000
Santa Clara Valley Medical Center	$ 74,768,040
Kaiser Foundation Hospital	$ 49,053,266
Alameda County Medical Center	$ 48,470,000
Children's Hospital of Los Angeles	$ 34,000,000
Natividad Medical Center	$ 32,892,762
Little Company of Mary Hospital	$ 29,000,000
Valley Presbyterian Hospital	$ 24,400,000
Redding Medical Center	$ 21,265,864
Citrus Valley Medical Center	$ 20,900,000
Sutter Amador Hospital	$ 20,000,000
University of California Davis	$ 20,000,000

Cesarean

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determine if there are people who can be identified as being educationally influential.

All physicians and nurse-midwives, who are credentialed to deliver babies at 52 randomly selected California hospitals, will respond to a questionnaire asking them to describe their obstetrical practices. The key section of the survey asks them to select which colleagues have the most influence on their obstetric practices.

The responses to the survey will be analyzed to determine if obstetric opinion leaders exist in California's hospitals and if we can identify them using a mailed survey. If this is possible, the opinions and beliefs of the leaders will be compared to those of other practicing clinicians. In addition, the relationship between hospital cesarean rates and the opinions of its obstetric medical staff will be examined.

Both projects are currently in progress, and any questions relating to them may be directed to Andye Zach, MPA, RRA, California Cesarean Projects Director, Health Policy and Planning Division, Office of Statewide Health Planning and Development, 818 K Street, Suite 200, Sacramento, CA 95814, 916-322-9138, E-Mail address azach@oshpd.cahwnet.gov.

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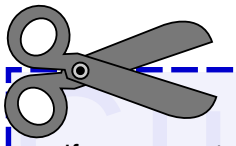

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